



I authorize release of any information concerning benefits directly to the dentist otherwise payable to me. I understand that Wild Smiles is a provider for All Delta Dental plans; United Concordia, National Fee for Service Plans; Cigna, Radius and Core Plans , We are in the process of adding other Insurance Companies, and will inform you as these changes occur. Therefore, your insurance carrier or payor to the dental benefits may pay less than the actual bill for services. Please check with your insurance to make sure we are listed as a provider otherwise you understand that you are financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by dental care payor. I understand I am responsible for any collection or legal fees if the account becomes delinquent. **This office reserves the right to charge a fee for broken appointments without a 24- hour notification. IF APPOINTMENTS ARE NOT CONFIRMED THEY WILL BE TAKEN OFF THE SCHEDULE.**

PARENT OF GUARDIAN'S SIGNATURE _____ DATE _____

SIGNATURE ON FILE

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND OR DEPENDENTS. I FURTHER AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY DENTIST TO SUBMIT CLAIMS FOR BENEFITS, FOR SERVICES RENDERED OR FOR SERVICES TO BE RENDERED, WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND OR DEPENDENTS. I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM.

I _____, HEREBY AUTHORIZE
(NAME OF INSURED)

_____ TO PAY AND
(NAME OF INSURANCE COMPANY)

ASSIGN DIRECTLY TO DR. G. RICK SINGH ALL THE DENTAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES DESCRIBED ON THE ATTACHED FORMS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED LESS ANY DENTAL INSURANCE BENEFITS WHEN RECEIVED BY AND PAID TO DR. G. RICK SINGH. AUTHORIZATION IS HEREBY GIVEN TO RELEASE ALL INFORMATION NECESSARY TO THE PAYMENT OF SAID BENEFITS.

_____ DATE _____
(AUTHORIZED SIGNATURE OF COVERED PERSON)



Practice Policies

We are committed to providing you with the best possible care. In order to achieve this, we need your assistance and understanding of the following policies

1. **Cancellations.** In the exceptional instance where an appointment must be canceled, we ask that you give us at least 24 hours notice so that we may use the space for someone else.
2. **No Show.** It is important for you to know that missing an appointment will not only slow treatment progress, but may alter it. We have adopted a policy that if a "no show" occurs more than twice, we reserve the right to discontinue treatment for your child. Our feelings are that not only has that parent not shown interest in their child's oral health, but they have taken that valuable time from another parent who shows genuine concern for their child's dental health.
3. **Emergency appointments.** Please call to alert us.
4. **Late.** If you are late for appointments (more than 10 minutes) we will attempt to treat your child but not at the expense of other patients who have arrived on time. You may end up having to reschedule. Please be aware that rescheduled appointments may take several weeks.
5. **Confirmation.** The office of Wild Smiles, LLC will make a courtesy confirmation call 48 hours prior to your child's appointment. It is imperative that we receive a confirmation of your child's appointment from you. In the event a confirmation is not obtained from the parent (because of ie., no answer, disconnection of phone service, or untimely response, etc.), Wild Smiles will reserve the right to remove your child's appointment from the schedule. It is, therefore, important that you make arrangements to contact us 24 hours prior to your child's appointment. **Wild Smiles, LLC will not take responsibility for any further attempts to contact you.**

Your understanding in our policies is greatly appreciated, for we do not feel we can make exceptions for one person. When, at times it seems as though we are inflexible with our schedule, please remember that we are trying hard to be on time and fair to everyone. We thank you in entrusting your child's care with us. We feel confident in our level of care. Welcome to Wild Smiles, LLC.

Signature of Parent

Date